Mental Hospitals

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Sunday morning worship services at Eastern State Hospital Williamsburg, Va. At the pulpit is the hospital chaplain, the Rev. Archibald F. Ward, Jr., Ph.D.; seated behind him is the Rev. Edward M. Brown, chaplain intern.

In this issue:

THIS MONTH'S COVER

Although Virginia's Eastern State Hospital, the nation's oldest public mental hospital, has no chapel, it does have an active religious program under the trained leadership of a chaplain. When the Rev. Archibald F. Ward, Jr., became the hospital's first full-time chaplain three years ago, his task of developing an effective religious program was aided immeasurably by the warm support he received from both within and outside the hospital.

Within, the program was given full support by the hospital's superintendent, Dr. Granville L. Jones, which Dr. Ward credits as being a prime factor in the program's success. He also found other departments willing to help. The Occupational Therapy Department, for instance, provides a music therapist to train the patient choir, sets up chairs for the service and otherwise transforms the "Rec" Hall into the "Re-Creation" Hall for the Sunday morning services.

Outside the hospital, a number of individuals and groups have contributed gifts and personal service to Dr. Ward's program. The solid walnut altar was made by the students of a Negro college in the state, the funds for it provided by a group of church women. The local garden club provides flowers for the altar each week. The choir robes and hymnals were the gifts of a public-spirited individual.

The chaplain's schedule is augmented by volunteer activities. A local Catholic priest celebrates Mass at the hospital once a week and visits Catholic patients. Jewish rabbis and members of their congregations come from thirty miles away for regular services and visits. The local Council of Church Women holds a weekly service in the women's geriatric building, and students from William and Mary College conduct services in other parts of the hospital for patients who are unable to attend the Recreation Hall service. The community's interest is further indicated by the fact that the hospital services are frequently attended by Williamsburg citizens.

Eastern State Hospital is particularly well situated for inviting community participation in its affairs, being physically and historically an integral part of Williamsburg. It has long enjoyed the benefits of a good reputation, not only in Williamsburg but throughout the state. The link between the religious life of the community and that of the hospital has provided an added opportunity for the citizens to demonstrate their willingness to help the hospital.

Dr. Ward notes that any program which seeks to utilize community resources in this way requires coordination, supervision, and some screening and orientation of the participants who volunteer. He feels, however, that this extra effort is well worthwhile.

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Massive Public Support, Adequate Budgets Needed for Psychiatry to Fulfill Obligations

Psychiatry, in its present stage of development, could greatly increase the number of discharges from public mental hospitals. It could also go beyond the problem of the actual mentally ill individual and contribute considerably to the mental health of the entire community. It is first necessary, however, to inform the public of the immensity of the problem, to make specific recommendations and establish top priorities, so that top-level public leadership could be induced to support such efforts on an adequate, nation-wide scale.

Psychiatrists interpreted and dramatized these statements at a one-day symposium on "Directions of Current Progress in Psychiatry," held at the Shoreham Hotel, Washington, D. C., on October 28th.

Representatives from the Foundations—Ford Foundation, Ittleson Family Foundation, Commonwealth Fund, Division Fund, Field Foundation and Russell Sage Foundation—listened as leaders in psychiatry delineated needs and directions in psychiatric research, education, prevention, and therapies. But first, said Dr. Kenneth E. Appel, past President of the A.P.A., a "Flexner Report" on the psychiatric facilities in this country was needed so that psychiatry, which had for too long tried to solve its problems in isolation, could obtain top-level public support with budgets adequate to the problem of mental ill health which is today costing the country billions of dollars.

Energetic discussion from the floor followed Dr. Appel's proposal. For too long, it was said, we have regarded the mentally ill in the same way that we used to regard the poor—saying that they will be always with us. Psychiatry is competent to take the necessary leadership and collaborate with its sister organizations to try to check this epidemic of our civilization—mental illness. Unless psychiatry is able to obtain the support necessary to assume this leadership, the job will be done anyhow, and done less well, by others lacking the valuable experience and insights which psychiatry can offer.

Specifically, therefore, a survey should be developed of all the psychiatric facilities in this nation—the mental hospitals, the state mental health programs, the research and education programs, the existing therapies and their evaluation and preventive psychiatric medicine—and presented in a concise, dramatic, readable form so that it will reach the public. Such a report should be so presented that every editor, every science writer, every representative of mass communication in the country would be eager to publicize it. Its purpose would not be to "expose" in a damaging sense, though some of the material it would contain would show much to be condemned. Its purpose would be to make concrete recommendations, establish top priorities and to show the people how, with public support, psychiatry, which has more than an academic concern with the destroyers of human happiness and productivity, could accomplish the task it has set itself.

This survey should not be made by the Government. Nor should it be made by any one organization, such as the A.P.A. It should be made by a group of organizations which are involved in the problem.

A Commission should be formed of representatives from various organizations, medical and otherwise, to conduct such a survey. Among those which should be considered were the American Psychiatric Association, the National Institute of Mental Health, the National Association for Mental Health, the Council of State Governments, the Veterans Administration, the Council on Medical Education of the American Medical Association, the Joint Commission on Accreditation, the American Board of Psychiatry and Neurology, the Board of Hospital Administrators, and the American Psychoanalytic Association. Perhaps this Commission should also

Yes, some hospitals are still "snake pits." The majority of public mental hospitals are more than 45% overcrowded. A survey of the type described at the symposium on "Current Trends in Psychiatry" would bring to top-level notice the crying need evinced by this picture taken last year in a public mental hospital.

include representatives from outside these groups—one from labor, perhaps, one from management, an economist and a representative from one of the great insurance companies.

This survey should contain not only facts, figures and recommendations on the care and treatment of patients now in mental hospitals, but also facts, figures and recommendations on how better to conduct research and education programs, evaluate therapies and conduct public education in preventive psychiatry.

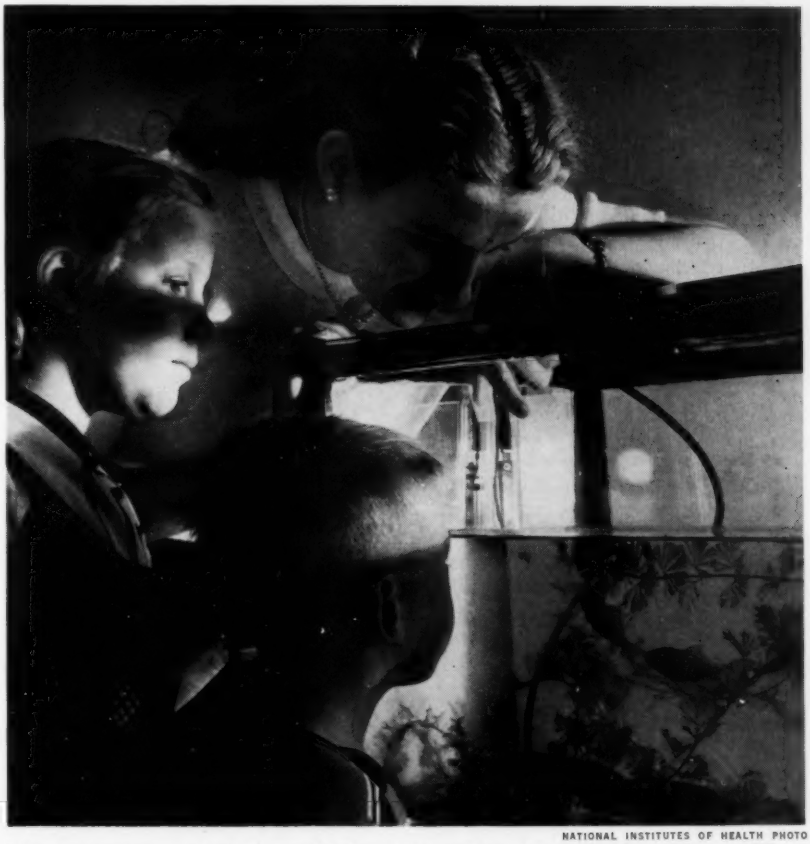
The first pressing need is for money for a preliminary planning commission, and then adequate support for the two to two and a half years which it would take to complete the work. When completed, the survey would be a blueprint for top national leaders, a catalyst of public opinion, a crystallization of professional thinking and a guide for future, drastic action on a national scale.

Such leaders as Drs. Arthur P. Noyes, John Whitehorn, Paul Hoch, William Malamud, Frank Curran, William Menninger and many others in free discussion periods, discussed current trends and needs already apparent. In effect these discussions served to indicate some of the facts and recommendations which would be contained in the proposed survey.

There was, for instance, a pressing need for more knowledge. Psychiatric research, perhaps more than any other scientific enquiry, refuses to be bounded by purely pragmatic considerations. The view that we simply want to discover the nature and causes of mental diseases, how to treat them and how to prevent them, is an oversimplification.

The broader goals of research are to stimulate curiosity—to uncover new questions as well as to discover new things. Every new set of data uncovers more questions than it answers, thus broadening the field of enquiry.

Nor can effective research be done by one person or by one discipline. The field of psychiatric enquiry must be broadened to include many peripheral fields—education, sociology, anthropology and physical medicine. An individual working in a basic science might properly be considered as engaged in psychiatric research because the most important contributions



NATIONAL INSTITUTES OF HEALTH PHOTO

The importance of child psychiatry is becoming increasingly evident. There are insufficient children's units, mainly because there are not enough trained people. More psychiatrists, social workers, occupational and recreational therapists are needed for the management of children's units as well as more psychologists and other disciplines for research.

made to psychiatry in the past have arisen as a side issue of pure research rather than as the goal of a specific enquiry. Perhaps we should scarcely even use the term "psychiatric research" implying as it does, the involvement of one discipline only. This opens up the question of cross-fertilization. Research workers need to travel, if necessary, to examine other enquiries into their own field. Without such comparisons, without opportunities to evaluate, discuss, compare, research will become sterile. Frequently, for instance, a bad idea sparks a good idea—an enquiry into one field leads to questions into another. A clinical enquiry may lead into a problem of dynamics—a biochemical question into one of environment.

Research needs in psychiatry need considerable clarification and interpretation if they are to become acceptable within our existing culture. The main lack in this field to date has been lack of ideas, which stems back to lack of man power. Able younger people, with no restrictions, should be encouraged and enabled to make pure research their life work. They need not only support but status—status independent of any socially acceptable results which they might produce. They should be, so to speak, endowed financially because they are already endowed mentally with the enquiring mind mandatory to successful research. Massive support of long term programs, holding little hope of results for ten or twenty years, may be the answer.

Research and education are fields which overlap in all considerations as to where development should be directed and support be given. Psychiatric education has many phases, but two vital ones are the education of the psychiatrist himself and the

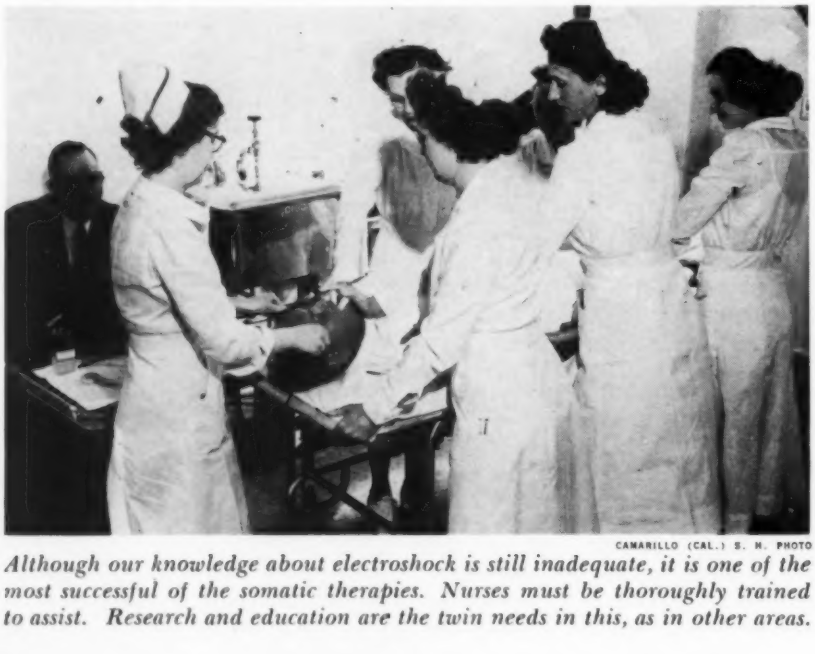
education of the general medical man. Europeans are often surprised to find that psychiatrists in this country actually teach psychiatry to medical students, yet the psychiatric enlightment of the general medical profession is certainly the most important single factor in preventive psychiatry.

There is a good deal of emotionalism connected with the provision of money to provide immediate improvement in the care and treatment of mental patients; yet the long term effects of money invested in the education of more young psychiatrists, and of more men prepared to be teachers of psychiatry might produce better long-term results. In what other way than by education can we hope to develop the needed research workers, the needed psychiatrists, the needed teachers to pass on their knowledge and experience to the many other disciplines required to help treat and care for the psychiatric patient, and the needed general medical men with good orientation in the psychological aspects of medicine?

Another field where emphasis should be placed is in relation to the value of existing therapies. New methodologies for evaluating and improving them is one of the main concerns of the A.P.A. Regional Research Conferences. Some questions which arise are: How can one evaluate "improvement"? How compare the relative value of different types of psychotherapy—individual versus group psychotherapy, for instance? What kind of patients benefit best from one or from the other? Probably both are "best" under certain conditions—but what are these conditions? What is the value of group psychotherapy for children? In trying to assess results, not all things can be evaluated by the same set of principles. Constant enquiries are going on to determine what measurements must be developed to evaluate progress in an individual. Ward studies, supported by different foundations, are of great value. Sometimes changes seem to result from situational rather than medical care. We must not fall into the ancient error of looking for the "single cause." A patient lives in a space of time during which many things happen to him besides therapy. We must find out what these things are and how they affect him. The more "milieu" studies can be conducted, in or out of hospitals, the better chance we have of ultimately reaching some genuine knowledge of what happens to the patient, and the better chance therefore, we have of giving him successful treatment or a correct environment. And this, of course, reaches out into the field of preventive and community psychiatry.

Preventive psychiatry involves nothing less than man's relations to man—the very problem of the survival of the race. By preventive psychiatry we mean much more than simply the prevention of mental illness—we mean, more dynamically, how to keep people well. It is impossible to wait until we know more—we cannot wait until we can prove it. Psychiatry has the general impression that it can do considerable good by applying knowledge it already has so that the man in the street can modify his motivation and thus his behavior towards other people. Public education will not wait for proof—demands are being made upon psychiatry daily, demands which cannot be met for lack of funds, lack of manpower. In one small but important area we have at last obtained $8,000 from Foundations to enable us to meet together with the leading editors and science writers of the country to see how psychiatry can do a better job in mass communication to disseminate to the public knowledge of mental hygiene principles. We need funds also for helping industry save the millions of dollars wasted annually by alcoholism, absenteeism and accidents—all caused by personality factors in people. Schools beg our help—one million teachers are confronted daily with all the difficulties which children have in growing up—yet we cannot give them enough professional advice. In speeding up the world we live in, we have also speeded divorce, delinquency, crime, admissions to mental hospitals. The clergy, confronting these problems, realize that counselling has a scientific value, and approach us for help. Again, we lack manpower, we lack funds. Yet positive prevention is a necessity if psychiatry is in any way concerned with man as a social being.

The needs of research, education, prevention and treatment in psychiatry need considerable clarification and interpretation if the public is to find our aims acceptable and urgent. This interpretation to man of his needs is the whole task of psychiatry. Man alone refuses to accept his social environment—he attempts to fix it, to change it, to modify it. Psychiatry has set itself the task of guiding men in their relationships to one another. This is the task. Psychiatry can, given massive support and dynamic leadership, find the way.



CAMARILLO (CAL.) S. H. PHOTO

Although our knowledge about electroshock is still inadequate, it is one of the most successful of the somatic therapies. Nurses must be thoroughly trained to assist. Research and education are the twin needs in this, as in other areas.

Medicine-Psychology Relations Defined by Medical Organizations

EDITORIAL

The Resolution on the Relations of Medicine and Psychology is a joint declaration of policy by the American Psychiatric Association, the American Psychoanalytic Association and the American Medical Association. It has been signed by the Presidents of these three Associations.

The question has been asked—what are the implications of this Resolution for mental hospitals?

The Resolution applies to mental hospitals, both public and private, in the same way that it applies to psychiatric practice in clinics, in universities and colleges, in general hospitals, in private practice and elsewhere. It is an affirmation of a scientific philosophy with regard to mental illness, a general statement of the type of training necessary for the diagnosis and treatment of mental illness, an acknowledgement of medical responsibility for the mentally ill, and a statement of the role of persons who have not had full medical and psychiatric training in the diagnosis and treatment of mentally ill persons.

Because of the lack of adequately trained psychiatrists in some mental hospitals, it is sometimes reported that non-medical personnel have performed medical functions, such as the conduct of psychotherapy, with little or no psychiatric direction.

It would appear that such activities are inconsistent with the intent of the Resolution, and should, in every case, be coordinated under more direct medical supervision. It would be expected also that the activities of non-psychiatric personnel be directed toward the areas for which they are trained in order that these groups may make their most significant contributions to the field of mental health.

Paul E. Huston, M.D.,
Chairman, A.P.A. Committee on Relations with Psychology

A resolution on the relations of medicine and psychology has been approved by the governing bodies of the three major medical organizations concerned with psychotherapeutic treatment. The Board of Trustees of the American Medical Association, the Council of the American Psychiatric Association and the Executive Council of the American Psychoanalytic Association have endorsed the following statement:

For centuries the Western world has placed on the medical profession responsibility for the diagnosis and treatment of illness. Medical practice acts have been designed to protect the public from unqualified practitioners and to define the special responsibilities assumed by those who practice the healing art, for much harm may be done by unqualified persons, however good their intentions may be. To do justice to the patient requires the capacity to make a diagnosis and to prescribe appropriate treatment. Diagnosis often requires the ability to compare and contrast various diseases and disorders that have similar symptoms but different causes. Diagnosis is a continuing process, for the character of the illness changes with its treatment or with the passage of time, and that treatment which is appropriate may change accordingly.

Recognized medical training today involves, as a minimum, graduation from an approved medical school and internship in a hospital. Most physicians today receive additional medical training, and specialization requires still further training.

Psychiatry is the medical specialty concerned with illness that has chiefly mental symptoms. The psychiatrist is also concerned with mental causes of physical illness, for we have come to recognize that physical symptoms may have mental causes just as mental symptoms may have physical causes. The psychiatrist, with or without consultation with other physicians, must select from the many different methods of treatment at his disposal those methods that he considers appropriate to the particular patient. His treatment may be medicinal or surgical, physical (as electroshock) or psychological. The systematic application of the methods of psychological medicine to the treatment of illness, particularly as these methods involve gaining an understanding of the emotional state of the patient and aiding him to understand himself, is called psychotherapy. This special form of medical treatment may be highly developed, but it remains simply one of the possible methods of treatment to be selected for use according to medical criteria for use when it is indicated. Psychotherapy is a form of medical treatment and does not form the basis for a separate profession.

Other professional groups such as psychologists, teachers, ministers, lawyers, social workers, and vocational counselors, of course, use psychological understanding in carrying out their professional functions. Members of these professional groups are not thereby practicing medicine. The application of psychological methods to the treatment of illness is a medical function. Any physician may utilize the skills of others in his professional work, but he remains responsible, legally and morally, for the diagnosis and for the treatment of his patient.

The medical profession fully endorses the appropriate utilization of the skills of psychologists, social workers, and other professional personnel in contributing roles in settings directly supervised by physicians. It further recognizes that these professions are entirely independent and autonomous when medical questions are not involved; but when members of these professions contribute to the diagnosis and treatment of illness, their professional contributions must be coordinated under medical responsibility.

LOAN LIBRARY ADDITIONS

Rules and Regulations for Canteens and Stores (*Dept. of Mental Hygiene, Calif.*) *Weight 1 lb.*

Training Course for Supervisors and Selected Charge Attendants (*Spencer State Hospital, W. Virginia*) *Weight 1 lb.*

Please enclose 15¢ in postage stamps for each volume requested.

FOOD AND THE MENTALLY ILL

By PAUL HAUN, M.D.

Clinical Director, Graylyn, Winston-Salem, N. C.

For many years hospital budgets have been set up on the tacit assumption that there is an inverse relationship between the patient's appetite and the food cost index. As the latter rose, the former dropped. Shrinkage in the purchasing power of the food dollar went hand in hand with a decrease in the basic daily caloric requirement.

With 20 to 50 per cent overcrowding in three out of every four hospitals, and with daily per capita expenditures averaging $2.04 for all aspects of patient care, therapeutically motivated individuals in certain mental institutions may find difficulty in deciding whether a patient's most pressing need is expert psychotherapy or a pair of shoes; whether his emotional conflicts or his institutionally-determined malnutrition should be given priority. The therapeutic choice is at times roughly analagous to offering a naked Bantu a chrome-plated pop-up toaster as against a sack of mealies.

It is easy to see how a hospital staff could become so discouraged over these unhappy facts, so distressed at the glacial apathy of society toward the mental hospital that medical initiative is lost and enthusiasm dampened in an endless succession of frustrations. The conscientious superintendent may even hesitate to urge necessary appropriations upon his Legislature, knowing that he will be unable to answer their questions as to where he can recruit a clinical director, a group of skilled psychotherapists, or a certified surgeon. Too often he is forced to admit that there are badly needed skills he simply cannot buy with money alone.

In this welter of apparent impossibilities, it is refreshing to identify one aspect of the problem which dollars *will* correct anywhere in the United States, no matter how isolated the hospital, no matter how badly it is understaffed, no matter how low its morale. That single, immediately correctable item is the patient's diet. Both the amount and the quality of food are exactly geared to the number of dollars spent in its purchase, and only money is needed to buy table silver and dishes, dining rooms and kitchens, even when the nearest town is a hundred miles away and the professional staff reduced to one graduate nurse and an elderly physician with heart trouble. Here is a budgetary item free of the niggling qualifications which complicate hospital operation in many other fields; one which every superintendent can defend to the hilt. Neither he nor the Legislature are gambling when they invest in food service. The results are as predictable as a sunrise.

Spring Grove State Hospital, Catonsville, Md.

Careful planning of procurement, menus and methods of preparation involve conferences between Director of Food Service, Mr. George E. Shipferling, from the Dept. of Mental Hygiene, the Head Dietitian of the Hospital, Miss Frances E. Gibson and the Head Cook, Mr. Edward Pivec.

Recruitment Not Difficult

Staffing a dietetic service will naturally involve many of the problems implicit in all mental hospital recruitment, yet it is fair to say that any institution which can function at all will be able to recruit for its dietetic service. The reasons for this are several. Skills required of dishwashers, waiters, counter-men, butchers, bakers and cooks are widely dispersed among the general population and require either slight modification or none at all to be effective in the hospital setting. Contact between employees and patients, a common source of irrational fear on the part of prospective employees, is relatively infrequent and ordinarily not intimate, and so affords a very minor deterrent to the worker. Few employees are assigned to the late evening and night shifts, widely considered undesirable by new personnel, while such especially skilled individuals as cooks and bakers have long ago accepted night and early morning work as characteristic of their trade.

Western State Hospital, Staunton, Va.

The cafeteria in the new Reception Building is pleasantly furnished; small tables encourage socialization; food service personnel help dietitians to supervise diet, at the same time allowing patients free choice of their food.

Obtaining the services of a qualified dietitian and of able administrative assistants offers the only major recruitment problem, yet even here the scale is tipped in favor of the hospital since the principal field for which the dietitian trains is the large institution, not the out-patient clinic and not private practice. Nor is employment in the specifically psychiatric setting without attraction to the dietitian. If the general hospital patient notices the food on his tray, it is usually to compare it with the meal he will be having at home in a few days, while the busy executive eating his hasty lunch in a commercial cafeteria scarcely knows whether he orders the fricassee or the roast.

In contrast, there are few assignments in which professional rewards are so direct or personal satisfactions so great as in the properly administered mental hospital. To have a new dessert the subject of animated conversation among hundreds of people, to see empty, back ward faces light up at the sight of a sparkling new dining room with *flowers* on the table, to be stopped a half dozen times a day for serious discussion of that special chicken pie on next week's menu, occurs in Heaven, where all good dietitians go, and daily in the good mental hospital. The nostalgia of the occupationally displaced dietitian for the good old days on the psychiatric wards, the compelling reasons her classmates find to turn down better located, better paid jobs outside the mental hospital field are not accidental whims. They speak for a rare degree of occupational satisfaction and are the predictable results of administrative competence in the superintendent's office, adequate money to finance a professionally sound program, and the warm, human sense of being needed, of being able to give something important to others. There is a psychological simplicity about the hospital dietitian's task which spares her the frustrations implicit in many other facets of patient care. Her amiable goal is to see that good food is expertly prepared, appetizingly seasoned and tastefully served in pleasant surroundings. All she needs is the Superintendent's nod and a certified check.

In contrast to simple domiciling, philosophies of *treatment* for the patient have, over the decades, swung repeatedly from pessimistic nihilism to intense enthusiasm. Today, professional workers are again in a period of soundly based therapeutic optimism and once more are able to think of the psychiatric invalid as a human being suffering from a treatable illness, not as a static product of immutable genetic disaster. When we think of the patient as a person rather than as an instance, an individual rather than an example of pathology, we are able to see his needs in human terms. Like King Richard, he too may say to us, "I live with bread like you, feel want, taste grief, need friends." With the regression common to all illness and seen most strikingly in mental afflictions, food takes on once more the profound symbolic value it had in earlier periods of development. A tasteless, skimpy meal slapped on a chipped plate and eaten with a tarnished spoon is deficient in far more than proteins, vitamins and minerals. Cold grease spilled over watery potato culls is hard to interpret as a gesture of compassionate interest in the welfare of another being. We can profitably meditate on the question whether it is always the untidiness of the patient which makes "trough feeding" necessary or the method itself, which, at times, bestializes his habits. The vast healing potential of love, which will never be measured in grams or in mice units, can find expression in the patience of a counter-man, in the smile of a dietitian, and in the humble comfort of good food.

Book Review

By LUCY D. OZARIN, M.D.

The Mental Hospital: A Study in Institutional Participation in Psychiatric Illness and Treatment. Stanton, Alfred H. and Schwartz, Morris S.; Basic Books, Inc. N. Y. 492 pp. $7.50.

The authors, Dr. Stanton, a psychoanalyst, and Dr. Schwartz, a sociologist, received a grant from the U.S. Public Health Service for the purpose of conducting a socio-psychiatric study of a mental hospital to determine whether the administrative practices of the hospital influence the clinical course of mental illnesses.

The study was carried out at Chestnut Lodge, Rockville, Maryland, a 60-bed private hospital. The majority of the in-patients are psychotic and the major form of treatment here is intensive psychotherapy. This hospital is well staffed with a personnel ratio of approximately 2.5 personnel for every in-patient. The staff psychiatrists are either psychoanalysts or analysts-in-training. At the time of the study, the nurses had some preparation in psychiatric nursing. The aides had little training for their duties. Ancillary workers such as occupational and recreational therapists were available. There was a high turnover of nurses and aides at the hospital.

The study was centered in a 15-bed women's disturbed ward. There was a psychiatrist administrator for the ward and each patient was assigned to a psychiatrist for psychotherapy.

During the two years the ward was studied, there was opportunity to confirm by direct observation that hospital practices do influence the behavior of patients and the course of their illness. The authors had hypothesized that many manifestations of the patient's behavior occurred as parts of definite social configurations. In the case of two symptoms, it was possible to find clear, specific and describable phenomena. One was excitement and tension which occurred when patients were the subjects of covert, affectively important staff disagreement. The excitement terminated when the staff members resolved their points of disagreement. The other phenomenon was incontinence which occurred at times when the patient felt isolated, abandoned, unworthy, or was in the midst of conflict. Incontinence also appeared to be inversely related to the fulfillment of patients' wishes or to the positive responsiveness of the staff. The authors assumed that repeated regressive behavior is an attempt by the patient to solve an institutional problem.

In the hospital the writers discerned both a formal and an informal structure. The formal structure comprises the organizational hierarchy and includes the rules and procedures that are subject to planning and change by direct order. The informal structure of the hospital, although also subject to change and influence, is difficult to describe or delimit and pertains to the attitudes, biases and personal relationships of the patients, staff and community. The phenomena influencing the patient's symptoms appear to arise in the informal structure of the hospital.

Two Influential Factors

The authors single out two factors which influence informal structure, namely, communication and power, or decision making. Communication is the cement which binds human relationships. Consensus (or agreement) or misunderstandings may make a difference in attitudes and courses of action. The observers found that both formal communication channels (line of authority) and informal communication channels often went awry. Failure to be kept informed was a frequent staff complaint. It is important for the supervisors and administrators who are on the upper end of the vertical channel of communication to be kept reliably informed. Often information is not transmitted or is transmitted incorrectly. Administrative practices suffer accordingly since decisions are made on the basis of information received.

Power is the location, within the social order, of a decision which will be enforced by the total social order or by its enforcing agents. The hospital offered an excellent opportunity to study and test the exercise of power. Power had to be delegated in the division of staff responsibilities. When this was successfully achieved, it was one of the most effective factors contributing to staff effectiveness and sense of well-being. It was also one of the most difficult social problems in the hospital.

The amount of time that personnel—doctors, nurses, aides—spend with patients, with staff, and in nonpersonal work, was analyzed. How patients spend their time was similarly observed.

The authors also selected for study the special case, or the patient who received highly individualized attention. Special treatment is defined as "belonging to a type of group in which wide variations are permitted and in which greater deviation from the norm is permitted by the group. Individualization is secured not by setting the person against the group but by altering the type of group structure." If this is true, the book states individualized care can be systematically planned but the authors give no formula for such planning. They intimate that personnel attitudes and a flexible hospital organization will be useful to this end. Economy need not be a deterrent. Delegation of power is a necessity. The authors state: "It seems likely that traditional institutional treatment has as one result the apathy and effective withdrawal of adult patients as well as of children and as another the stultification and boredom or withdrawal of the personnel."

The outcome of treatment at the hospital was surveyed although there has been no follow-up to determine readmissions. It is the reviewer's impression that the discharges of schizophrenic patients from this institution are only a little higher than those reported by public mental hospitals. However, the patients at Chestnut Lodge have usually been ill for several years when accepted for treatment.

This book is well written, fairly easy to read and documented by many brief, well-chosen verbatim examples of recorded data. The literature of administrative psychiatry is reviewed and an excellent bibliography is appended. The book provides stimulating and provocative reading and furnishes a basic pattern for the mental hospital of the future.

Not the least to be commended are the senior administrators of Chestnut Lodge who were willing to expose to study and to public view the most intimate details of their hospital. Their courage and unselfishness deserve the appreciation of all who are concerned with mental hospitals.

ARCHITECTURAL SUPPLEMENT

Mental Hospitals

DECEMBER, 1954

ARCHITECTURAL STUDY

A State Facility for the Blind Retarded

by MALCOLM J. FARRELL, M. D., Superintendent, Walter E. Fernald State School, Waverley, Mass.

This unusual facility for a specialized group of patients makes use of large window areas of glass. Overcrowding is kept to a minimum. Special tubular steel-frame beds are so constructed that they can readily be made higher or lower as required. For lack of time it has not been possible to present floor plans but it is hoped to reproduce them in a subsequent Supplement.

GREENE BLIND UNIT, WAVERLEY, MASS.

Occupational Therapy Shop

September 13, 1954 marked the beginning of the first complete academic year in the new Ransom A. Greene building for the Blind at the Walter E. Fernald State School. This $1,800,000 unit will attempt for the first time anywhere in this country the treatment, instruction, care and training of large groups of blind retarded children. Named for Dr. Ransom A. Greene, a former superintendent of the School, the two-story modern design school and dormitory building provides for approximately 250 patients with complete facilities for their physical and psychiatric care, education, training and recreation.

It is interesting to note that the Fernald School was organized 107 years ago as a part of the then Massachusetts School for the Blind, now the Perkins Institution for the Blind. It was the first institution in this country for mentally retarded children. Methods in the care, education and training of the retarded were pioneered in the new unit. About 1880 its growth was such that it required separation from the parent institution and it was moved to Waltham, known also as Waverley, Massachusetts.

The need for a facility for the blind retarded was recognized by the Massachusetts Legislature in 1945 when it directed that a Commission be formed to investigate and study the advisability of establishing an institution for the care of blind feebleminded, blind epileptic, and blind feebleminded epileptic persons in the Commonwealth. This Commission was directed to make a report to the General Court on the results of its investigation, to make recommendations, and to draft any legislation necessary to carry its recommendations into effect. This Commission, of which Dr. Ransom A. Greene was a member, filed a report in January 1946, recommending among other things that two buildings for the blind retarded be built on the grounds of the Walter E. Fernald State School. A bill was passed by the Legislature and signed by the Governor in 1946 authorizing the preparation of plans to construct a building. Construction was actually started in November 1952 and the first patients were received in February of 1954. In addition to the school rooms and dormitories mentioned above, the building also includes a gymnasium, swimming pool, beauty shop, barber shop, cafeteria, and library. Complete provisions have been made in the library for the use of Talking Books.

Facilities are available for psychotherapy, both individual and group, physiotherapy and treatment of minor accidents and sickness.

Since the legal limit of blindness in Massachusetts is 20/200 uncorrectable in one eye, everything has been done to highlight brightness for those who can see dimly. Occupational therapy shops have been provided where training will be given under the supervision of registered occupational therapists. One of the few concessions to the child's loss of sight is in the swimming pool. Near the edge of the pool the deck rises slightly, warning the swimmer that he is nearing the water. While the facilities of the pool and gymnasium will be made available to others in the population, swimming is particularly helpful for the blind because it develops self-confidence and improves co-ordination which is so important for them. One end of the swimming pool can be divided off by a net and used for hydrotherapy of victims of cerebral palsy, poliomyelitis, and other neurological conditions.

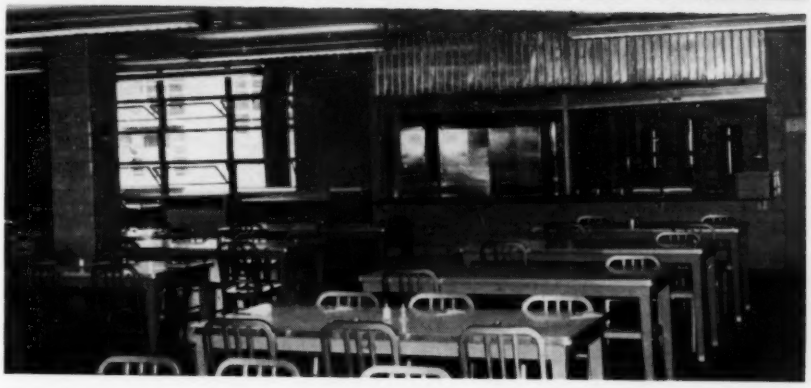
Radiant heating is used extensively throughout the building. Bathing facilities are provided so that an individual or pupils from an entire ward may be bathed at one time. Outside the build-

Nursery

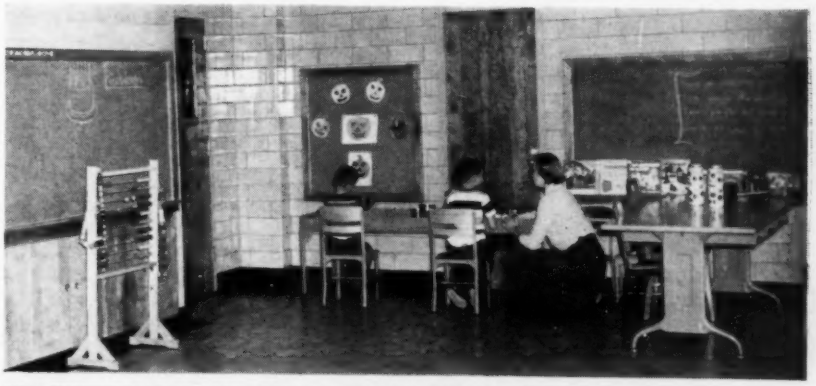
ing are concrete walks suitable for roller skating and paved with cork asphalt. Bordering the cork asphalt are three feet of sand to warn the running child that he will bump into a wire fence if he does not stop.

In the short period since the opening of the building, we have had some opportunity to acquaint ourselves with the problems which are presented in the education and training of the blind retarded. It has been found advisable to carry on instruction individually or in groups of two or three because complete rapport between teacher and pupil must be established before actual training can begin. The children are first observed on the ward until the teacher becomes so familiar to the child that she no longer presents an additional threat in a new environment. Many of these pupils have been neglected or over-protected by their parents. Also many have been constantly exposed to educational failure and have been so thwarted and humiliated by their environment that each one presents an entirely different educational and emotional problem. However, in our brief experience the results have been startling. Two little boys are already beginning to read Braille, to acquire number sense, and to use the Perkins Brailler. Some children and adults have completed units of work in the Occupational Therapy classes. Much enjoyment is gained through individual music lessons and group singing. The less advanced pupils are less inhibited and are gaining self-confidence to the point where appropriate instruction can be undertaken. The greatest needs of the blind retarded pupils appear to be in the area of social adjustment. We are well aware that we must continue in an experimental frame of mind since we have no experience to guide us.

Just as 107 years ago the Commonwealth of Massachusetts answered the need for an institution for retarded children in an institution for the blind, so the Commonwealth today has answered the need for an institution to train the blind retarded in an institution for the retarded.



Above: Barber Shop and Cafeteria. Below: A Class Room and Beauty Shop



THE PATIENT DAY BY DAY

Ward Plays Hostess to Community Group

By JOSEPH ADLESTEIN, M. D.
Danville (Pa.) State Hospital

A women's ward of Danville State Hospital was recently the scene of a party that proved to be a most enjoyable event, socially, and a considerably significant one, therapeutically. Sixty members of a local Professional Women's Club had accepted the patients' invitation to be their guests at an informal party.

The idea of the party was originated by the hospital as an experiment in creating a "normal" social situation for these patients, to help reassure them that they would be acceptable in such situations when they returned home. The women's club was first approached to see if the members would be interested in attending such a party. The club greeted the idea warmly. The patients then were asked if they would like to entertain the club. They were most enthusiastic and eagerly organized committees to plan decorations, refreshments, invitations, and a tour of the ward. Staff assistance was kept to the barest minimum, and in order to keep the occasion as informal as possible—and thus to allow more opportunity for sociability among individual guests and hostesses—no organized entertainment was planned.

Employees appeared out of uniform for the occasion and were indistinguishable from the patients in the receiving line at the open door. The event went off without complication. Even very sick patients responded; one withdrawn patient made her first voluntary social gesture when she noticed a guest looking ill at ease and offered to show her around.

The hostesses expressed considerable pride in "their hospital" to the guests. Contrary to what had been expected, they talked freely of their illness and took delight in showing the club members around the ward and describing the various therapies used.

An unexpected result of the event was the impact upon the aides, nurses and physician who worked on this ward. During the party almost all of them experienced difficulty in associating names with their patients' familiar faces—a difficulty that had not arisen in the weeks that they had worked with these patients! It raised a perplexing question in their minds: had they unconsciously cast all the patients into the role of "a patient," with its inherent expectations and limitations; had they perhaps insisted upon the patients' continuing to play this role, even as they were getting well, rather than encouraging development of their individual personalities?

Most of the patients, however, considered it a personal triumph to appear so different to the personnel, and are eager to hold another such party.

To all concerned the party proved to be a very meaningful experience, as well as an enjoyable one.

Doll House for Play Therapy Made by VA Patients

Dr. John G. Howard, Director of the Out-Patient Service at University Hospital, Little Rock, Ark., watches his young patient explore the doll house made by regressed patients at the North Little Rock VA Hospital.

Occupational Therapy

REGRESSED PATIENTS MAKE DOLL HOUSE FOR CHILD CLINIC

The doll house used in play therapy at the University of Arkansas mental hygiene clinic, shown on this page, was made by twelve schizophrenic patients at the VA Hospital in North Little Rock. The twelve were young regressed patients from the acute disturbed wards. They were over-active, assaultive on the ward, suspicious, and unable to socialize.

The building of the doll house was undertaken as an occupational therapy project at the suggestion of their ward physician, who felt that if the men could be encouraged to work together on a group project, they could be helped to accept each other. The idea was proposed to the men on the basis that their efforts would benefit little children in another hospital.

The pattern for the house was worked out by the patient who headed the group. Several of the men were able to work independently, doing the more complex tasks involved; others were able only to paint or sand with considerable supervision. There were no incidents of assault or violence in the O.T. clinic during the project.

With its builders' approval, the finished doll house, complete with open stairway, electric lights and a fireplace, was turned over to the University clinic for use in play therapy.

DONALD C. PRITCHARD, Exec. Asst.
Physical Med. & Rehab. Service
North Little Rock (Ark.) VAH

Recreation By Prescription

By W. K. FREEMAN, M.D., Manager
and
CARL R. FRIDLUND, Chief, Special Services

Veterans Administration Hospital, Gulfport, Miss.

The accelerated recreation program at this hospital is making a substantial contribution to the overall care and treatment program for our 1100 neuro-psychiatric patients. Since its inception in 1946 on an enlarged basis with increased staff, the recreation program has been accepted by the professional staff as an ancillary service providing an approved therapy for mental patients. The hospital's Chief of Professional Services and the ward psychiatrists participate with the Chief of Special Services and the recreation staff in planning the overall recreation program. This insures that specific activities are formulated which will contribute to patient recovery. They see that these activities are evaluated and adapted where necessary, and determine the extent of participation by certain patients.

With this type of support from the medical staff our recreation program has graduated from being a desirable adjunctive service to a medically accepted therapeutic tool.

The recreation program has two primary aims: first, to assist the doctor in getting his patients well; second, to make life as meaningful as possible for those patients who must remain in the hospital for long periods. It operates under the hospital's Special Services Division, as do the chaplaincy, library and voluntary service programs. The twelve full-time employees of the Recreation Section include the chief of the section, three social recreation leaders, one radio program director, a sports supervisor and four sports leaders, and two motion picture projectionists. They are assisted by trained volunteers from the Gulfport area.

Participation of patients in the recreation program generally is on a group basis, but for special activities such as the Stamp Club, the hospital newspaper, radio announcing and script work, the individual patient is assigned on a prescription basis.

An average of 140 social recreation periods are held each month in the Recreation Hall and on the 14 wards of the hospital. The activities are geared to meet the needs of the patients and to suit their physical and mental capabilities. Thus the program must be flexible and allow for special adaptations. The recreation staff must also provide a diversified program that will attract and hold the interest of patients. Every effort is made to stimulate voluntary participation, and special attention is directed toward the withdrawn patient, who constantly requires friendly gestures and sympathetic understanding from the staff to rejoin the current of activities.

The size of the groups participating in the social recreation program varies from 20 to 125 participants, and it is most important to have sufficient trained personnel aided by well-trained volunteers to make this phase of recreation effective.

Special Activities Prescribed

The special activities of the Recreation Section are carried on in close cooperation with the medical staff. In the film program, for instance, the patients who aid the projectionists are medically prescribed for this special training. Films are shown thrice-weekly for ambulatory patients in a centrally located recreation hall and ward showings are held for infirm patients. In addition, special film showings are held three times a week for patients scheduled to receive electroshock therapy, as a means of alleviating their anxiety.

Another activity which receives attention from the medical staff is the hospital newspaper, which is prepared and distributed by patients assigned to the activity on the advice of their ward psychiatrists.

An excellent and well-balanced program of adapted sports is conducted six days a week for approximately

Patients from two locked wards compete in a basketball game at Gulfport VAH. Their previous disinterest in sports was overcome by the constant encouragement of the athletic attendants in charge of this prescribed sports activity.

700 patients. All are assigned on a prescription basis, with the exception of privileged patients who participate at will. The medical service prescribes 12 hours a week of intensive sports for the disturbed wards of the acute intensive treatment service. The number of hours assigned for other patients varies according to their capacities. Modified or adapted sports are used with chronic psychotic patients in contrast to the intensive, highly active type held for the acutely disturbed. All sports activities are carried on in outdoor areas well developed for the purpose. In inclement weather, a modified program is conducted on the wards. The sports program is considered an essential part of the total treatment program and is making a positive contribution to patient recovery.

The Recreation Section also conducts club and hobby groups, special holiday events, tours and outings, and music and drama activities for patients.

It has been shown that patients who learn to adjust well in the socializing atmosphere of an effective recreation program will certainly be more responsive to other therapies. In this and many other ways recreation plays an important part in the total treatment program for neuropsychiatric patients.

PROFESSIONAL CONFERENCES

Nurses Assume Leadership in Aide Education

Members of the nursing profession have expressed the opinion that the functions required of psychiatric aides call for an organized course of study to be provided for these workers, since in-service programs alone are not proving adequate. The appropriate curricula committees of the National League of Nursing have been directed to study this matter further, bearing in mind the relative positions of the practical nurse and the psychiatric aide in determining needs for education programs and advisability of licensure.

This opinion and recommendation was expressed at the second meeting of the Special Committee on Psychiatric Nursing, formed by the ANA-NLN Coordinating Council last year to study how better nursing care could be given to psychiatric patients. This committee includes representatives from the A.P.A., the A.H.A., the N.A.M.H., the U. S. Public Health Service, the VA, the Council of State Governments, the National Association of Licensed Practical Nurses, the Office of Vocational Education of the U.S.P.H.S., schools of psychiatric nursing and psychiatric hospitals.

Three previous workshops, sponsored by the A.P.A. and the N.A.M.H., have consisted of psychiatrists, nurses and psychiatric aides, each of which has discussed its concepts of psychiatric nursing care in order to arrive at a common understanding. It is apparent that the nursing care of patients in public mental hospitals is almost entirely in the hands of aides. For lack of registered nurses, aides are performing duties ranging from bathing patients to giving medications and assisting at shock therapies. Training varies widely from lengthy courses of instruction which lead to higher salaries for aides who have successfully completed them, while elsewhere patients are cared for by aides with little or no prior training or supervision. Two basic needs emerge—to interest and recruit more registered nurses into hospital psychiatry and to adequately educate psychiatric aides for their duties.

There is every indication that the Special Committee on Psychiatric Nursing will continue as a group to consider how best organized nursing can move in a concerted manner to meet the needs of the mentally ill. This assumption of leadership by the discipline which bears the full responsibility for round-the-clock care of the mental patient is of vital significance to hospital psychiatry.

NLN and APA Cooperation Discussed

Representatives of the National League for Nursing met recently with Miss Elsie Ogilvie, Nursing Consultant of the A.P.A., to discuss areas of cooperation between the two organizations. The League spokesmen were Anna Fillmore, General Director; Helen Nahm, Director of the Division of Nursing Education; and Kathleen Black, Director of the Mental Health and Psychiatric Nursing Advisory Board.

The group agreed that it is desirable for the APA and the NLN to work together as much as possible in consultation and accreditation services that relate to psychiatric nursing education. The possibility of exchanging information on specific programs and of working cooperatively on these programs will be explored.

Discussion brought out that the best possible ways must be found for all types of institutions—universities, general hospitals and special hospitals—to work together in nursing education.

Since the attitudes of students toward emotional needs of patients and toward psychiatric nursing are influenced by graduate nurses in staff, teaching and supervisory positions, APA and NLN representatives were in accord that educational opportunities should be provided for graduate nurses who have had inadequate basic preparation in psychiatric nursing. Workshops and conferences can fill this need in some measure.

Recruitment problems in psychiatric nursing and educational needs for graduate nurses in the psychiatric field were also considered.

It was agreed that as more hospitals develop up-to-date, effective programs of treatment of patients, good personnel policies, good living conditions and stimulating programs of in-service education, the problem of recruitment and retention of graduate nurse staff tends to diminish.

Hospital Planning Conference Told Needs of Psychiatric Facilities

Several types of educational efforts to gain support for providing more psychiatric facilities were proposed by Dr. Charles K. Bush in an address to the Conference on Hospital Planning held in Chicago in September. Dr. Bush, Director of the APA-M.H.S. Architectural Study Project, was one of several speakers who addressed the Conference, which was sponsored jointly by the American Association of Hospital Consultants, the American Institute of Architects, and the American Hospital Association.

Dr. Bush outlined briefly the present and projected need for psychiatric facilities, emphasizing that buildings alone are not sufficient. Where the buildings are located and how the services they house are understood and used by the public have much bearing on the success of a mental health program.

Education is necessary to ensure that the proper steps are taken, he said: namely, education of the public to accept mental illness as a sickness, of legislators and state authorities to realize the economic wisdom of preventive measures and early treatment, and of all them to support the placement of mental institutions in professionally advantageous urban areas.

He urged also the education of general hospital administrators to include psychiatric facilities for both inpatient and outpatient care. He suggested that the administrators should visit mental hospitals and "see for themselves that 95% of all admissions could be cared for easily in a general hospital setting."

Occupational Therapists Consider "Core Curriculum"

One full afternoon was devoted to psychiatric topics in relation to Occupational Therapy at the 37th Annual Conference of the American Occupational Therapy Association held in Washington, D. C. in October. Mrs. Gail S. Fidler, O.T.R., was chairman and Dr. Jay L. Hoffman, F.A.P.A. was moderator at this meeting which included presentations by three psychiatrists, an occupational therapist, a psychiatric nurse and a sociologist.

One of the more provocative contributions derived from the observation of one of the speakers who suggested that the particular crafts practiced by the occupational therapist and her patients appear to be less significant than the interpersonal relationships which are developed. Since such relationships are also important in the work of others in the hospital, such as psychiatric nurses, social service workers, etc., there exists a need shared alike by all such persons for a common training program. The goal of such a program would be to teach the workers how to use themselves and their relationships with patients in a therapeutically beneficial manner.

From the foregoing there develops logically the idea of a common "core curriculum" of training—perhaps at more than one level—for all who work with patients on the wards of our mental hospitals. Several benefits to be expected from such a program, even in the smaller hospitals, are readily apparent. There would be an economy in the use of the hospital's available teachers and the more stimulating teachers could be made available to a greater number of trainees. There would be established a uniform and authoritatively inspired curriculum which would be offered to all trainees alike. And the members of the several disciplines represented in the classes would be brought into contact with each other, would teach each other in unplanned and unscheduled but often effective ways, would come to know each other and, with knowledge, mutual respect and cooperation would receive an early foundation. Certainly further exploration of the "core curriculum" idea is indicated.

Both the American Occupational Therapy Association and the American Psychiatric Association have standing committees concerned with the closer co-ordination of the two professions. At least one member, Dr. Benjamin Simon of Arlington, Mass., of the A.O.T.A. Medical Advisory Council is a psychiatrist. It is in the interest of psychiatrists, who need skilled assistance such as occupational therapists can provide in a total treatment program, to be familiar with the potential contributions of the O.T.R. It is to the interest of the occupational therapists to take the fullest advantage of advances in psychiatric understanding and its slowly crystallizing improvements in formulation and expression.

Younger psychiatrists in training often overlook occupational therapy as an aid in patient treatment; the reason they usually give is that they are more interested in the dynamics of individual psychotherapy. There is, however, a dynamic formulation to be offered for occupational therapy, albeit as yet expressed only imperfectly and incompletely. In this connection attention is called to the recently published book, "Introduction to Psychiatric Occupational Therapy"* by Mrs. Gail S. and Dr. Jay W. Fidler, Jr.—occupational therapist and psychiatrist. Published by Macmillan Company, ($4.00) this is the first formal attempt in book form to present occupational therapy in a dynamic frame of reference familiar to the young resident in psychiatry. This happy collaboration of occupational therapist and psychiatrist should be repeated.

JAY L. HOFFMAN, M.D.

Food Service Should Be Medical Responsibility

"Food and the manner in which it is served strongly influences the mental and emotional status of hospital patients," said Dr. Ralph M. Chambers, of the Central Inspection Board, speaking before the 37th Annual Meeting of the American Dietetic Association in Philadelphia in October.

"It is difficult to understand why Food Service in so many hospitals is operated without professional direction," Dr. Chambers continued. "The prime need is for the superintendent to accept his responsibility for the Food Service as a medical problem, and to encourage a qualified dietitian, assisted by an adequate number of properly trained persons, to put the nutritional as well as the emotional needs of the patients above all other considerations. The superintendent and the dietitian must be partners in the service of good, non-monotonous food in a pleasing manner according to established dietetic standards. Only thus can it be brought home to the whole hospital staff as well as to the public and to the legislators that the well-fed patient is the one to whom psychotherapy can be applied with the best results."

The mentally defective child presented yet another problem, said Dr. Gale H. Walker, superintendent of Polk State School, Pa., another guest speaker. The defective child frequently showed resistance to new foods, so that proper feeding called for time, patience and ingenuity. Nor was the correction of nutritional deficiency and growth failure solely the responsibility of the dietitian in such a school—it must involve the whole professional team.

Dr. Paul Haun, Assistant Professor of Psychiatry at Bowman Gray School of Medicine, Winston-Salem, N. C., reminded listeners that patients who worked in the food service should be there because the activity was considered therapeutic and not because the hospital needed unpaid help.

"Application of this philosophy," he said, "would mean reintegrative activity for patients who could derive personal benefit from it, and would imply clearly defined, though carefully limited, therapeutic responsibilities for each dietetic staff member who had contact with patients. . . ." He added that the absence of patient help for a day or month should not disrupt operations.

Miss Clarice Gullickson, Veterans Administration Central Office, and the dietitian-chairman of the Joint Committees of A.P.A.-M.H.S. and A.D.A. gave a report on the activities of this group, concluding with the recommendations which were formulated at the last meeting, and which were published in the February 1954 issue of MENTAL HOSPITALS.

DEPARTMENTS

Equipment

HOSPITAL-MADE MACHINE CUTS SCRUBBING CHORE

To relieve the dietary personnel of Kentucky State Hospital of the tedious task of cleaning 50 to 100 gallon steam kettles by hand, the hospital's engineer designed and constructed a piece of machinery to do the job. He made it primarily of salvage material from the hospital. A five-foot flexible drive shaft was purchased and coupled to a one-half horsepower motor, which was mounted on a small wooden frame on casters so that it might be conveniently moved from place to place, and a small wire brush was hooked to the drive shaft. No clutch was used and the control of the device is by a regular line switch.

If a fine enough wire brush is used the effect is almost identical to that of steel wool. One worker, with this piece of machinery, can clean all of the steam kettles in the kitchen in the time it took to clean one by hand.

FRANK M. GAINES, M.D.
Commissioner
Ky. Dept. Mental Health

Training

COOKS TRAINING PROGRAM IMPROVES FOOD SERVICE

The Provincial Mental Hospital, Essondale, B. C., has established a Cooks Training Program to improve food service and give some measure of standardization in the hospital's eight kitchens. Students are chosen from the staff of male kitchen helpers on the basis of their seniority of service, ability and enthusiasm for learning, attitude towards work, and rate of absenteeism. A minimum education of high school entrance is required.

The course is divided into Meat Cutting, Rangework, Baking and Dessert Preparation. Theoretical and practical instruction are co-ordinated. The art of meat cutting is taught by the bone structure method. Preparation and curing of meats, rendering of fat and care of refrigerators is included. The course includes the preparation of all types of desserts, cakes, quick breads and yeast products.

Half the course consists of Rangework which covers meat cooking, vegetable preparation and the making of soups, sauces and salads. The use and care of modern equipment is stressed in all phases of the course.

As this training program is concentrated into eight months it qualifies an employee only for the position of a junior cook who will then gain more practical knowledge working under supervision.

C. L. NEIGHBOR
Chief Dietitian
Provincial Mental Hospital
Essondale, B. C.

KANSAS INAUGURATES ADVANCED AIDE TRAINING

A new inservice training program setting higher qualifications for aides in all Kansas state institutions has been formulated by the Committee on Employee Education of the State Department of Social Welfare. The Committee is composed of one or more staff members of each of the state hospitals and training schools, and the assistant director of institutions.

The program specifies minimum curriculum standards for the institutions, to which each may add other subjects to meet special needs of its nursing service. Persons applying for the training must be high school graduates and eligible for college work. The program has been approved by the State Board of Social Welfare, the State Hospitals Superintendents' Council, and Dr. George W. Jackson, Director of Institutions.

Those who sucessfully complete the course will be designated Aide I. They then will be eligible, after a period of satisfactory work performance, to apply for Aide II training. This course is designed to prepare them to become Charge Aides. Aide II trainees will be able to apply for college credits for part of the course. Details of the more advanced course are being worked out by the education committee to present to the Superintendents' Council.

Administration

PROPERTY CONTROL SYSTEM KEEPS TABS ON EQUIPMENT

A property control plan initiated at Enid (Okla.) State School several years ago has been revised to provide more adequate processing of property documents.

Each article of equipment and property is numbered by decal and a card listing the corresponding number with complete description of item, purchase order number, price and source, plus delivery date or condition, is kept on file in the Business Manager's office.

Each department head or cottage supervisor receives a loose-leaf manual containing a complete list, in numerical order, of the property assigned to that particular unit.

The supervisor in charge signs for the manual, accepting the property as listed. No property is moved, even for repair, from a building until authorization is issued by the Business Office. Items taken to the shop for repair are tagged and a duplicate stub left on the cottage, to be collected when the repaired item is returned.

A system of control cards has been set up. When an item is moved from one building to another, after proper permission is granted, a pink card is dropped into the file, and the white (original) card is forwarded to the new location. When the item is damaged to the extent that it cannot be repaired, a green card replaces the original white property card, which is then placed in the inactive file.

Every movement-of-property card includes the authority for movement or for final disposition.

Property control not only keeps an up-to-date index of all property and equipment, but also has served as a guide to the efficiency of the operation of a department. Units, for instance, that continually have furniture in need of repair, indicate management difficulties which need investigation.

The system has proved to be a very useful means of assuring proper care of the school's physical assets.

ANNA T. SCRUGGS
Superintendent
Enid (Okla.) State School

Clothing

STAFF EFFORT IMPROVES PRIVATE CLOTHING SYSTEM

In evaluating, during 1952, the problems of providing clothing for our patients, at Pacific State Hospital, it became apparent that there were many unmet needs if we were to follow through on our concept of providing a more family- and community-like life. The Nursing Service personnel's desire to clothe patients better, in a more appropriate and therapeutic manner, was evident. One person was designated to explore all the possible resources for clothing and devise methods of procurement and disbursement.

On investigation, we discovered that many parents and relatives did provide clothing for the patients most willingly and it was felt that on a more organized basis other parents would appreciate the opportunity to do the same. All patients were divided into twelve units (months) by birth dates and inquiry cards were sent to each cottage to determine the patients' clothing needs and sizes. All known parents and relatives were contacted through a standard letter and the lists of suggested clothing needs were sent out a month before the patient's birthday. Recommendations that parents purchase clothing maintained most easily in relation to the degree of the patient's handicap were systematically worked out. They were also encouraged to take an interest in providing funds for dry cleaning garments which required it. For the less retarded patient, clothing suggestions were divided into work clothing and dress clothing, allowing patients to state preference in colors and styles suitable for wear in the hospital. This fitted into our program of emphasis on patients' learning good grooming. For the moderately retarded patient, we suggested washable garments which are colorful and attractive. For extremely retarded, bedridden patients, the parents could either purchase various specialized articles or send money for them.

As this began we immediately became aware of the satisfaction that many parents had in making the patient's life happier through providing some of the essentials to his welfare. This also provided an opportunity for the parents to bring some satisfactory gift to the patient which he would enjoy and which would be useful as well. Many parents were most grateful for these itemized suggestions and although some of them were unable to provide all of the items, many continued to send suitable articles throughout the year. For new admissions or newly contacted relatives, supplementary periods of the year were used, such as Christmas and Easter, to send out request letters. This met with good results.

Patients who had no parents or relatives who responded, either because they were financially unable or were unknown, were placed on an alternate file, so their needs could be taken care of through donations. These donations came in through parents and relatives who were able to provide extra items, or interested individuals and organizations in the community. Both of these sources were followed up by receipts and letters thanking them for providing better services to our patients. This has resulted in a continuous response.

It was also the responsibility of the person coordinating this program to improve the techniques of handling large quantities of clothing. Centralized marking and disbursement of all clothing provided better and more effective distribution. All clothing items coming in from parents and relatives were checked for size, fitted and sent to the marking room before the patient was allowed to wear them. With this method clothing control on the cottages became more effective. Clothing donations of all kinds were cleaned and repaired. The cottage personnel brought patients in to the marking room for fitting of clothing, which was marked before being sent to the patient's cottage for the individual patient.

This better organization and management of procuring and disbursing private clothing has made it possible for the hospital to purchase more attractive and high quality items of clothing from State funds allotted for this purpose. Parents and friends of the hospital have assumed their rightful responsibility and interest in our patients' welfare and, most of all, patients are happier and have pride in their dress.

DORSEY L. MOUNT
Pacific State Hospital
Spadra, California

Simple Activities for Post-Shock Patients

At Metropolitan State Hospital, Norwalk, Calif., a regular part of the duties of the recreational therapist is to work with patients following electroshock, playing simple games to restore their sense of reality. Mr. Gridley Dorr encourages one with the bean bag toss, while another patient is playing ring toss.

PUBLICATIONS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

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VOLUME V